

**Investigation into the death of a man in February 2012
while in the custody of HMP Brixton**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2013

This is the report of an investigation into the death of a prisoner at HMP Brixton, who died in February 2012. The man was found hanging in his cell. The post-mortem examination concluded the cause of death was asphyxia (suffocation). I offer my condolences to his family and friends.

The investigation was carried out by one of my investigator. A clinical reviewer was commissioned to review the man's clinical care at Brixton. Staff at Brixton cooperated with the investigation. I apologise that this report is late.

The man was remanded into custody in March 2011 but, due to concerns about his mental health, he transferred to a mental health hospital in December 2011. In January 2012, he appeared in court and was found guilty. Because of the time he had spent in custody, he was released on licence, but he was recalled to custody two days later, on 19 January, after being charged with another offence.

When the man arrived at Brixton, he was monitored as at risk of suicide and self-harm and referred to the mental health team. He was given a single cell on the mental health inpatient wing. Initially, he would not interact with staff or other prisoners and would not participate in suicide and self-harm monitoring or mental health interventions. In the weeks leading up to his death, he started to engage a little more with staff and prisoners. There was little clear indication that he intended to take his life.

The clinical review concludes that the man's clinical care was at least equivalent to that which he could have expected in the community. However, despite being generally well supported by prison officers and the mental health team, the man refusal to engage appears to have led staff not to follow the correct suicide and self-harm procedures. There was no systematic assessment of his risk factors, nor were multi-disciplinary reviews undertaken. Some important information about the man's self-reported previous attempts at suicide was not shared. Overall, it is a concern that his risk of suicide and self-harm was continually assessed as low, despite some indicators which would have suggested a higher level of risk. However, it is not possible to know whether improved processes could have affected the outcome.

The recommendations made in the draft report have been accepted by HMP Brixton. I have included the prison's response to the recommendations at the end of this report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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SUMMARY

1. The man was born in Lithuania. He died in February 2012 at HMP Brixton after being found hanging from the bed frame in his cell.
2. On 30 March 2011, the man was remanded into custody and arrived at HMP Brixton on the same day. He transferred to HMP Pentonville on 1 July. On 9 December, he man moved to a mental health hospital, where he stayed until his appearance at court in January 2012.
3. On 17 January 2012, the man was sentenced to 18 months imprisonment at Crown Court. Due to time already served on remand he was immediately released on licence. His hospital assessments showed that he did not meet the criteria for further detention under the Mental Health Act. However, he was arrested for an alleged further offence committed on the day of his release and returned to custody. He arrived at Brixton on 19 January 2012.
4. The man refused to talk to prison and healthcare staff for reception and health screening interviews. A suicide and self-harm monitoring and support plan was started and he was referred to the mental health team. He lived on the mental health inpatient wing (D wing).
5. The man initially refused to cooperate with mental health staff and would not speak to other staff or prisoners. However, in the weeks leading up to his death he started to engage more with staff and other prisoners. Prison and healthcare staff believed that he had “turned a corner”.
6. At around 9.05pm on the day of the man’s death, a prison officer discovered the man suspended by strips torn from a bed sheet tied to the frame of his bed. Staff cut the sheet from the man’s neck and body, and nurses attempted to resuscitate him. When paramedics arrived they took over the man’s care but he was pronounced dead at 9.20pm.
7. A clinical reviewer carried out a review of the man’s clinical care at Brixton which he found to be at least equitable with what he could have expected in the community. We are concerned that the suicide and self-harm (ACCT) process was not carried out in a systematic way and that the man’s wider risks were not considered. It is impossible to say whether this would have made a difference to the outcome. We make two recommendations about the effective use of the self-harm and suicide monitoring process and assessment of risk.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the man's death on 27 February 2012. The investigator issued notices to staff and prisoners at Brixton informing them of the investigation and asking anyone who had relevant information to contact him. No responses were received.
9. NHS Lambeth commissioned a clinical reviewer to carry out a review of the man's clinical care during his time in custody. The clinical reviewer's report was received on 29 May 2012.
10. The investigator visited Brixton on 2 March and spoke to the Governor and staff involved in the man's care. He examined all the man's relevant prison and medical records. The investigator returned to Brixton on 4 and 27 April and 28 May, to conduct interviews with staff and prisoners. Initial feedback was given to the Deputy Governor on 28 May and subsequently confirmed in writing.
11. HM Coroner was informed of the investigation and provided a copy of the post-mortem report. Our report will be sent to the Coroner to assist his enquiries.
12. One of the Ombudsman's family liaison officers contacted the man's brother. She outlined the purpose of the investigation and gave him the opportunity to identify any matters which he wished to be considered as part of the investigation. He did not raise any issues.
13. We apologise that the issue of this investigation report has been delayed due to pressure of work.

HMP BRIXTON

14. At the time of the man's death HMP Brixton was a local prison serving a number of courts in South London and holding up to 798 men. Healthcare services are commissioned by NHS Lambeth and delivered by a group led by Care UK, including the South London and Maudsley NHS Foundation Trust with pharmacy and other services provided by Lambeth Community Health.
15. Brixton has now changed its function to a category C prison with a particular emphasis on resettlement. The prison no longer accepts prisoners on remand and the inpatient unit where the man lived has closed.

HM Inspectorate of Prisons (HMIP)

16. HMIP last conducted an inspection of Brixton in December 2010. The report expressed serious concerns about D wing and the use of the suicide and self-harm monitoring for all prisoners on the wing. The report made the following comments:

“The most disturbing sight in the prison was the inpatient mental health care. Some young men, who had been sectioned, were waiting for up to six months for a place in a secure mental health hospital. Some cells were in a very poor state of repair with ripped linoleum floors, graffiti on the walls and dirty toilets without seats.”

17. The report also recorded that at the time of the inspection 41 prisoners were being monitored on suicide and self-harm monitoring forms, 18 of whom were on D wing. It goes on to say that many of the prisoners on D wing had mental health problems but did not present as an active risk of suicide or self-harm, yet were still managed under the ACCT process. The Inspectorate recommended that there should be a specific case management structure for prisoners on D wing who were not evidently at risk of suicide and self-harm.
18. Inspectors noted that there was a structured regime for inpatients with mental health problems, including sessions with an occupational therapist and a weekly ward round by a consultant psychiatrist. The report also said that a specialist registrar psychiatrist was available daily and at least four registered mental health nurses were on duty most days.

Independent Monitoring Board (IMB)

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Brixton covers the year to 31 August 2011. The IMB considered that D wing was unfit for purpose, but was maintained as well as could be expected. The Board was concerned that the constraints of the prison regime and accommodation were inappropriate for men with severe mental health problems.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a Caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

Previous deaths at Brixton

21. Before the man's death, the last self-inflicted death at Brixton was in 2008. Both were deaths from hanging (the most common form of self-inflicted death in prisons) but there were no other similarities between the circumstances of the man's death and that of the other prisoner.

KEY EVENTS

22. The man was born in Lithuania. He had lived in the United Kingdom since 2010 and was able to speak and understand English.
23. On 30 March 2011, the man was remanded into custody and he arrived at HMP Brixton on the same day. This was his first time in prison. At a health screen interview when he arrived, it was recorded that he had injured his left eye a number of years ago. He said he had no other medical problems.
24. In 1 July, after a further court appearance, the man transferred to HMP Pentonville. On 8 July, Assessment, Care in Custody and Teamwork (ACCT) self-harm and suicide observation procedures were started as staff were concerned that he was not eating, refused to leave his cell and would not communicate with them. Staff tried to conduct a case review the following day, 9 July, but he refused to engage in the process. He was also referred to the mental health team. The ACCT was closed on 19 July, when he began to eat and talk again. He spent some time on the segregation unit following an assault on a member of staff. On 5 August, due to concerns about his mental health, he was admitted to the healthcare centre where he remained for the rest of his time at Pentonville.
25. On 25 October, the man appeared at Crown Court. The court decided that he should be examined by a psychiatrist to determine whether he had mental health problems and whether he was fit to stand trial. On 2 November, a clinical psychiatrist saw the man who said he had no thoughts of suicide or self-harm and was planning for the future when he was discharged from prison.
26. On 11 November, consultant psychiatrist A, saw the man and recorded that he was "irritable and guarded". In her full medical report she said that he was suffering from a mental disorder within the meaning of the Mental Health Act. She said it was appropriate for him to be detained in hospital and he was in urgent need of treatment.
27. On 9 December, the man was transferred to a mental health hospital. In his report prepared for the man's court appearance, consultant psychiatrist B, said that he was not previously known to mental health services in the United Kingdom. The man had reported attempts of self-harm several years previously, when he was an illicit drug user. Consultant psychiatrist B reported that the man said he did not have any thoughts of suicide or self-harm at that time. Following further assessments it was decided that he did not meet the criteria for further detention under the Mental Health Act, but he remained at the hospital until his court hearing.
28. On 17 January 2012, the man was sentenced to 18 months imprisonment. Due to time already served on remand the man was released immediately on licence. He was arrested the next day for another alleged offence and was recalled to custody.

29. The man arrived at Brixton on 19 January. During the reception process he refused to speak to staff and would not even confirm his personal details. He would not answer any questions about his health and did not make eye contact. It was decided that an ACCT plan should be started and that he should be observed with intermittent observations (six times an hour) until his ACCT assessment was completed.
30. Nurse A, who carried out the reception healthscreen, was concerned about the man's mental health and referred him to prison doctor, A. The doctor saw him the same day and decided that the man should be referred to the mental health team and admitted to the mental health inpatient wing (D wing). Nurse B noted that on his arrival on the wing the man appeared to be low in mood, but there were no signs of any attempted self-harm.
31. When an ACCT is opened, an assessment is expected to be completed within 24 hours. The man refused to interact with staff and be interviewed for an assessment. No assessment was carried out based on the information available. The first case review did not take place until 10 days later, on 29 January. The man did not attend.
32. During the afternoon of 20 January, psychiatrist A saw the man. She recorded that he refused to cooperate when she tried to interview him. She spoke to the man at his open cell door but he asked her to leave immediately. She wrote that he "was threatening in his manner advising me not to persist with any attempt to engage him".
33. During the morning of 21 January, an immediate action plan (part of the ACCT process which should have been carried out no more than 24 hours after the ACCT was opened) was completed. The purpose of this plan is to consider and record the most appropriate environment and regime to support the person at risk. The following actions were recorded for the man:
 - He should remain in a single cell
 - There should be under general observation
 - He should have access to a telephone when required
 - He should have access to a Listener when needed (Listeners are prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress)
34. Three days later, on 23 January, the man was seen by psychiatrist B, but he still refused to communicate. The psychiatrist recorded that although the man "often behaves in bizarre and unsocial ways, he has no record of self-harming, nor of random violence outside of particular arguments or situations he provokes". The psychiatrist decided that the level of observation was to be reduced from intermittent observations to general observation (in line with the immediate action plan) and there should be "three quality entries" in his ACCT record every 24 hours. The man also continued to refuse to participate in the ACCT process. That evening an entry in the ACCT plan stated that the man appeared calm but was still isolating himself and not interacting with staff or prisoners. He had his meals and did not appear distressed.

35. The next day, 24 January, the man was seen by psychiatrist C, during his ward round. The psychiatrist recorded that the man was “guarded, evasive and inappropriate”. As a result he was unable to obtain any background information. The psychiatrist planned to book the man into consultant psychiatrist A’s clinic for a review.
36. On 26 January, the man attended a local magistrates’ court and was again remanded into custody.
37. On 27 January, there was a further unsuccessful attempt to interview the man for an ACCT assessment. He was again seen by psychiatrist A and agreed to speak to her. She noted that he had a previous history of drug abuse and did not want to take medication for his mental health problems. She also noted that the man said he had attempted suicide five times in the last two years, but had not self-harmed before that. He told her that he had travelled to the United Kingdom in 2010 to look for work. The man did not provide any information about whether he had registered with a GP practice. This information about previous self-harm was recorded on the man’s medical record but not in his ACCT documentation. Regarding his mental health she recorded that the man said he had “occasional thoughts of suicide but denied any current thoughts or intentions, increasingly feels may have a future”.
38. Psychiatrist A said that the man claimed he was hearing voices (auditory hallucinations) which were often critical of his past, although he said he did not hear voices telling him what to do (command hallucinations). She recorded that the man believed he had psychological problems but did not want to take any medication as he believed he could resolve the problems himself. However, he was grateful for the support he was receiving. She recorded that she would need to review the medical records from the man’s time at Mile End Hospital and details of his offending history.
39. Another unsuccessful attempt was made to interview the man for an ACCT assessment on 28 and again on 29 January. There had still been no ACCT case review. Security Manager A made the following entry in the man’s ACCT record on 29 January: “It is not acceptable that a review has not taken place since the prisoner was placed on ACCT 10 days ago. Even if he will not engage with us we must document everything we are doing to get him to talk to us and to support him”.
40. Security Manager A held a case review, with Officer A and Nurse C during the afternoon of 29 January. The man did not attend. In the summary of the case review, Officer A said that the man spoke English but would not engage with the assessment process or speak to staff about his situation. It was agreed that both officers and healthcare staff, would try to get the man to engage and that these attempts would be documented. It was also recorded that he was to be assessed by the psychiatrist and would remain on D wing. Although the likelihood of further risky behaviour was recorded as low, it was decided to keep the ACCT plan open. The information about his previous self-harm recorded by psychiatrist A, two days earlier, was not referred to and no other risk factors were identified or discussed. The next ACCT case review was

scheduled for 2 February and a Caremap was drawn up by the security manager with two action points:

- Continued efforts by staff to get the man to speak to them
- To be reviewed by a psychiatrist.

41. On 30 January, the man attended an occupational therapy group where it is recorded that he interacted well with other prisoners. On 31 January, the man was seen again by psychiatrist B at his own request.
42. On 2 February, the man again attended Thames magistrates' court and was again remanded into custody. The same day he refused to participate in the ACCT process. The scheduled ACCT review was not held. However, five days later, on 7 February, he agreed to attend the ACCT review. In the summary of the review it was recorded that the man was "down" and "fed up" having spent so much time in custody but that he said he did not have any thoughts of self-harm. He said he did not require any medication but wanted to get out of prison. The level of risk was reviewed and remained assessed as low, the frequency of observations also remained the same (general observations with quality entries recorded three times a day), conversations and recording requirements remained the same. The next review was arranged for 20 February.
43. A week later, on 14 February, a psychiatrist, D, reviewed the man. She recorded that he was not sleeping, was pacing up and down his cell but was attending groups, although his presentation was "variable".
44. The man attended an ACCT review, on the morning of 20 February, with psychiatrist D and Nurse C. The man said he felt very depressed because he could not think straight while in prison, but he denied any thoughts of self-harm. It was decided that the ACCT plan should remain open to monitor his mental state; the level of risk was reviewed and again recorded as low. The next review was arranged for 1 March.
45. Psychiatrist D saw the man later on 20 February. She recorded in his medical record that he did not want to see a psychiatrist, was "very guarded, and would not give any information". She said that he appeared quite paranoid and said that he felt depressed, stressed and worried about the food he was receiving. He told the doctor that he did not have any thoughts of suicide and said it was "his problem not hers if he wanted to kill himself". The man said that he heard voices all the time including the psychiatrist's and the voices of people outside his cell.
46. Psychiatrist D told the investigator that the mental health team's plan at this point was to continue to assess the man's mental state while in prison but not yet to make a referral for transfer to hospital for assessment under the Mental Health Act. They considered that he could be managed in prison for the time being and that further attempts to make an assessment of his mental health should be pursued. He had recorded in the man's medical record that she had read the discharge summary from the man's admission to hospital from

December 2011 to January 2012. She said that before admission to hospital there had been concerns that the man was paranoid and unpredictable. (He had assaulted a member of staff in July 2011 while he was at Pentonville). He also recorded that while he had been in hospital there was no clear evidence of psychotic symptoms and the man was not found to have a mental disorder of a nature or degree to warrant ongoing admission. He was described as “mute on occasion, guarded and isolated and this presentation appears to be similar during his time on D wing”.

47. On 21 February, psychiatrist D noted that the man remained suspicious of others and was pacing his cell. She also noted that he was now spending time on association and playing the guitar. He attended some groups and had been “appropriate” but was usually reluctant to engage. That night, Nurse D noted that the man appeared more settled during the night, had not paced around his cell, and seemed to have slept well. However, the next day he was observed pacing around his cell and refused to come out. He complained of a headache and was given paracetamol.
48. On 23 February, the man attended Thames magistrates’ court but was told he was not required there and needed to attend a local magistrates’ court, where he was again remanded in custody. It was noted on the ongoing ACCT record that the man was quiet, but seemed okay. On 24 February, the man appeared calm and was noted to be quiet. Staff noted that he had tidied and mopped his cell, and that he was “pleasant and polite”. During association he interacted with other prisoners. He did not express any thoughts of self-harm to staff.

Saturday the day of the man’s death

49. At around 6.25am on the day of the man’s death, it was recorded that the man was pacing up and down his cell for a while and, after he had requested a light for his cigarette, went back to bed and slept. At around noon, he was given paracetamol tablets for a headache. He also asked for an eye patch and was told that an appointment would be made for him to see the prison doctor about his headaches and he could ask about the eye patch then. At around 3.00pm, staff noted that he remained settled and had cleaned his cell. Just over an hour later, at around 4.05pm Nurse D recorded that the man had gone out for exercise and spent time out on association.
50. Nurse D told the investigator that she saw the man around 7.05pm when she was responding to a cell bell call for another prisoner. The man was standing by the door of his cell and he tapped on the observation glass and requested a lighter. The nurse lit a cigarette for him. The last time the nurse saw the man was about an hour later, at around 8.00pm, when he was standing at the door of his cell looking out.
51. At around 9.05pm, while carrying out a routine check of all the prisoners, Officer A opened the flap in the man’s cell and saw him suspended from a number of strips of torn bed sheet around his neck, wrists and legs which were attached to his bed frame.

52. Officer A called for assistance from his colleague Nurse B and they were joined by Nurse E. Officer A broke the seal of his emergency key pouch and with Nurse E went into the cell. They used an anti-ligature knife to cut the sheets and release the man. He was then laid on the floor of the cell. The officer radioed for assistance (using "code 1" – prisoner not breathing) and asked for an ambulance to be called. Nurse B began cardiopulmonary resuscitation (CPR)¹ but there was no response and the man was very cold to the touch. Nurse F also arrived. The records show that an ambulance was called at around 9.10pm and paramedics arrived at 9.18pm. Unfortunately, the man could not be revived and the paramedics pronounced death at 9.20pm.

Contacting the man's family

53. The prison chaplain, acted as the family liaison officer. The man had not given any next of kin information when he arrived and had no visitors while he was in custody. This meant that the prison chaplain was initially unable to contact the man's family. He liaised with the police and the Lithuanian Embassy who contacted the man's brother (who lives in the UK) and informed him of the death. On 6 March, after getting information from the Coroner's office and the Lithuanian Embassy, the prison chaplain spoke to the man's brother, who visited the prison on 8 March. Arrangements were made to return the man's belongings to his brother. In line with Prison Service guidance, financial assistance was offered for the costs of the man's funeral. A memorial service took place at Brixton on 8 March 2012.

Support for staff and prisoners

54. Prisoners were informed of the man's death during the morning of 26 February and asked whether they required any additional support, including through Listeners (prisoners selected and trained by the Samaritans to offer confidential support to fellow prisoners in distress). All the prisoners who were subject to self-harm and suicide monitoring were reviewed.
55. Prison managers held a meeting (hot debrief) for staff immediately involved to share information and provide reassurance and support.
56. The investigator talked to the prisoners in the cells next door to the man. Prisoner A said that he had only spoken to the man briefly to give him a light or a cigarette. He said he had heard the movement out on the landing when the staff and paramedics were attending to the man on the night of the man's death, but he had not heard anything before this. Prisoner B said that he had tried to engage with the man in the days before he died but had failed. He said he had sometimes given the man cigarettes but he did not mix with other prisoners. Prisoner B knew that the man was from another country and he had assumed that he did not speak very good English. He was also aware of the incident, but did not hear anything before the man was discovered.

¹ Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

Post-mortem report

57. The post-mortem examination recorded the man's death as being due to asphyxia (suffocation) caused by aspiration of stomach contents and ligature compression of his neck.

ISSUES

Medical care

58. A review of the man's clinical care was undertaken by the clinical reviewer. In his review, he notes that the healthcare records demonstrate that the Mental Health In-reach Team at Brixton were routinely in contact with the man and reviewed his care. The clinical reviewer found that the man's transfer, in December 2011, from Pentonville to hospital for assessment and treatment for mental disorder was completed efficiently and to the required standard.
59. Like the Inspectorate and the IMB, the clinical reviewer considered that the wing used as a mental health inpatient unit at Brixton was not a suitable environment to provide mental healthcare. The prison has since changed its role and D wing no longer operates as a mental health inpatient unit.
60. From the available evidence it appears that the man had mental health problems before his arrival in custody. Unfortunately there was no access to his medical records held abroad and there was no information to suggest that the man had registered with a GP since his arrival in the UK in 2010. Staff found it difficult to engage with the man although they clearly tried hard to do so, but this added to the difficulties of carrying out a comprehensive and meaningful psychiatric assessment. The clinical reviewer found that the psychiatric oversight, supervision, assessment, and care planning were of a high quality, and meetings with the man were frequent and regular, and his care was closely monitored.
61. The clinical reviewer concludes that the quality and level of clinical care the man received in Brixton was at least equal to that he could have expected had he been in the community.

The emergency response

62. An officer discovered the man hanging in his cell at about 9.05pm in February, while conducting a routine evening check. The officer quickly radioed for and received assistance, and an ambulance was called. Staff had cut the man down and started attempts at resuscitation within minutes. Paramedics arrived eight minutes after being requested and they continued to try to resuscitate the man. Sadly, they were unsuccessful in their attempts and he was pronounced dead at 9.20pm.
63. In his review, the clinical reviewer found that the action taken by staff after they discovered the man "was appropriate and met the required professional standards". From both the records and the investigator's interviews with staff it appears that, after the man was discovered, all of those involved acted quickly and in a professional and considerate manner.

Suicide and self-harm monitoring

64. When the man arrived at Brixton on 19 January 2012 he would not speak to staff, would not make eye contact and was described as low in mood. Staff were concerned that he might be at risk of harming himself and as a result suicide and self-harm monitoring (ACCT) arrangements were put in place. The same day he was referred to the mental health team and was admitted to the mental health inpatient wing (D wing).
65. There are a number of actions which Prison Service guidance says should take place quickly after an ACCT document has been opened. An immediate action plan should be put in place within an hour of an ACCT plan being opened which should be superseded by a caremap within 24 hours as the plan to keep the prisoner safe. A trained assessor should have made an ACCT assessment within 24 hours and this should be followed by a case review. All of these actions are to assess the prisoner's risk of harm to himself and to help ensure that an appropriate level of support is put in place.
66. The man refused to engage with staff and this appears to have thrown the process off course. The immediate action plan was not put in place until two days later, on 21 January, and the ACCT assessment interview did not take place because the man refused to cooperate.
67. Although the man declined to be interviewed for an assessment, we consider an assessment of his risk factors and what needed to be done to reduce the risk should have been completed based on the available and documented information about him. There were a number of known risk factors that should have been considered as part of an initial assessment, such as the fact that he had been recalled to prison, his ongoing court appearances and remand, and his status as a foreign national. His mental health problems, lack of outside contact and his withdrawal and refusal to engage exacerbated his risk. The man's immediate action plan indicated only that there should be 'general observation' but it is apparent that the man's risk was regarded as relatively high as the ACCT documents from the time of his arrival show that he was observed very frequently – five times an hour.
68. When psychiatrist B saw him on 23 January, he apparently decided that the man's observations should be reduced to general observations (as his immediate action plan indicated) and that there should be three quality entries in his ACCT document each day. Such decisions should only be taken at multi-disciplinary ACCT case reviews. There appeared to be confusion between mental health care and the ACCT process on D wing and at that stage there had still not been a formal ACCT review.
69. It was not until 29 January, ten days after the ACCT was opened, that a first ACCT case review was held, attended by the security manager, Officer A and Nurse C. The man did not attend. Discussion centred on the man's mental health problems rather than any of his other risk factors and how they could be addressed. Although the man had told psychiatrist A on 27 January that he had attempted suicide five times in the previous two years there is no evidence

this was discussed. The review assessed his risk as low but without any consideration of his known risk factors. A Caremap was put in place following this review, but this dealt only with issues about the man's mental health.

70. A scheduled case review for 2 February was not held apparently because the man refused to attend, but the review should have gone ahead without him. A further two case reviews were held on 7 February and 20 February. The man and staff from the mental health team attended both of the case reviews. Again the information he had given about previous attempts to kill himself was not discussed or recorded in the ACCT documentation. This was information that should have been considered as part of his ongoing risks. As a result his risk continued to be assessed as low.
71. We are concerned that the ACCT process was not used effectively to assess and support the man and did not follow the Prison Service guidance. There was a failure to identify and record his risk factors in a systematic way and important information about his risk was not shared and discussed. We note that in the days before he hanged himself he described himself as depressed and was often seen pacing about in his cell. He had a further court appearance on 23 February when he was again remanded into custody - a major cause of his anxiety. We cannot know whether a more coordinated and organised approach to the ACCT procedures would have saved the man but we consider it unlikely that a thorough multi-disciplinary discussion of his risk factors would have reached a conclusion that his level of risk was low.

The Governor should ensure that staff fully take into account all the available indicators when assessing the risk of self-harm in prisoners and are alert to changes in circumstance and demeanour which might indicate increased risk.

The Governor should ensure that ACCT procedures are followed in line with Prison Service guidance to ensure that prisoners identified as at risk of suicide and self-harm are appropriately assessed and supported at regular multi-disciplinary ACCT reviews.

CONCLUSION

72. The man arrived at HMP Brixton in January 2012. He was put on suicide and self-harm monitoring and referred to the mental health team immediately, because of concerns about his mental health. He did not initially engage with staff although this appeared to have changed in the days leading up to his death. During the evening in February 2012, the man was found to have hanged himself using strips of torn bed sheets. Attempts to resuscitate him were carried out but unfortunately these were unsuccessful.
73. The clinical reviewer concludes that the quality and level of mental health care the man received was equivalent to what he could have expected in the community.
74. Although the man had good support from the mental health team and other prison staff, the ACCT process was not used in a systematic way and Prison Service guidance was not followed. This meant that the man's level of risk did not take into account his wider risk factors and almost entirely concentrated on his mental health problems. It is possible that better risk assessment would have led to increased observations but we cannot know whether this would have changed the outcome.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

1. The Governor should ensure that staff fully take into account all the available indicators when assessing the risk of self-harm in prisoners and are alert to changes in circumstance and demeanour which might indicate increased risk.

Staff are fully aware of the importance to take into account all risk factors when assessing prisoners including any changes in circumstances and demeanour. The importance of risk factors when assessing a prisoner at risk has been communicated to all Assessors and Case Managers and included in the current training.

2. The Governor should ensure that ACCT procedures are followed in line with Prison Service guidance to ensure that prisoners identified as at risk of suicide and self-harm are appropriately assessed and supported at regular multi-disciplinary ACCT reviews.

ACCT procedures are followed in line with Prison Service Guidance and appropriate assessments take place and supported at regular multi-disciplined ACCT review. This is monitored through: Senior Officer daily checks. Wing Manager Weekly Checks. SPC briefing every morning (Monday to Friday) at Residential Meeting.